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IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., NAIM S. KASSAR, M.D., REPRODUCTIVE HEALTH SERVICES and ALLEN S. PALMER, D.O.,
Respondents,

vs.

JOHN ASHCROFT, Attorney General of the State of Missouri, and RALPH L. MARTIN, Prosecuting Attorney of Jackson County, Missouri,
Petitioners.

On A Writ Of Certiorari To The United States Court of Appeals For The Eighth Circuit

BRIEF OF RESPONDENTS

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THE QUESTIONS PRESENTED FOR REVIEW

Respondents adopt the "Questions Presented for Review" as contained in "Brief for the Cross-Petitioners" (hereafter "Defts. Br. ____") at I.

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BRIEF OF RESPONDENTS

OFFICIAL REPORTS OF OPINIONS BELOW

Respondents adopt the "Opinions Below" as contained in "Brief for the Cross-Petitioners" (Defts. Br. 1-2).

STATEMENT OF JURISDICTIONAL GROUNDS

Respondents adopt the statement of "Jurisdiction" as contained in "Brief for the Cross-Petitioners" (Defts. Br. 2).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Respondents adopt the "Constitutional and Statutory Provisions Involved" as contained in "Brief for the Cross-Petitioners" (Defts. Br. 2-4).

STATEMENT OF THE CASE

I.

The In-Hospital Second Trimester Requirement (MO.REV.STAT., § 188.025)

In the United States during the year 1981, 82.1% of all early second trimester abortions (13-15 weeks) were performed by the D&E method and 54% of all second trimester abortions from 13-20 weeks. *Center for Disease Control Abortion Surveillance, 1978,* U.S. DEPT. H.E.W., November 1980, Table 14 at 43. Defendants' own expert Dr. Nathanson agreed. (J.A. 144). In Missouri, 99.3% and 99.7% of all second trimester abortions were performed by the D&E method in 1979 and in 1980, respectively. (Transcript on Remand 71-72 [hereafter "T.R. ____"], Henshaw). In Missouri, in 1979 all second trimester abortions performed by the D&E method were performed by Truman Medical Center, a hospital in the Kansas City, Missouri area. (Joint Appendix 167, 170 [hereafter "J.A. ____"], Schramm). The District Court's opinion voiding this Section was filed on January 23, 1980. ("Cross-Petition for a Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit" at A-1 [hereafter "Cross-Pet. ____"]).

Prior to 1980, this Section proved to be an extremely successful effort by the State of Missouri to thwart the full exercise of abortion rights and to reduce drastically the total number of abortions performed. Requiring an in-hospital procedure after 12 weeks gestation had virtually eliminated abortions after 12

weeks gestation in Missouri, by reason of the astronomical costs, increased patient risk, additional time delay imposed, the unavailability of resources, and the loss of anonymity, all associated with such in-hospital procedures. In those states permitting post-12 week abortions to be performed at facilities consistent with the attending physician's best medical judgment, statistics clearly demonstrated a greater number of procedures being performed post-12 weeks.

In 1976, 90.0% of all abortions in Missouri were performed prior to 13 weeks gestation, while other midwestern states, having no similar in-hospital requirement, averaged only 80% of their total abortions prior to 13 weeks gestation. (*E.g.*, Kansas, Minnesota, Nebraska and South Dakota). In 1976 Missouri accounted for 34.5% of all abortions performed prior to 13 weeks gestation within the combined states of MO, KS, MN, NE and SD; yet in the same year Missouri accounted for only 10.0% of all abortions among those combined states during the post-12 weeks gestation period. Approximately 1,499 abortions were prohibited by this in-hospital restriction in Missouri during 1976. *Center for Disease Control Abortion Surveillance, 1976,* U.S. DEPT. H.E.W., August 1978, Table 16 at 33. (Plaintiffs' Trial Exhibit 1 [hereafter "Plts. Tr. Ex. ____"], Trial Transcript 865, 866 [hereafter "T. ____"]).

In 1977, 94.1% of all abortions in Missouri were performed prior to 13 weeks gestation, while the combined states of KS, MN, NE and SD averaged only 81.9% of their total abortions prior to 13 weeks gestation. In 1977 Missouri accounted for 35.0% of all abortions performed prior to 13 weeks gestation within the combined five states; yet Missouri accounted for only 10.9% of all abortions within those combined states during the post-12 weeks gestation period. Approximately 1,389 abortions were prohibited by this in-hospital restriction in Missouri during 1977. *Center for Disease Control Abortion Surveillance, 1977,* U.S. DEPT. H.E.W., September 1979, Table 16 at 43.

In 1978, 91.5% of all abortions in Missouri were performed prior to 13 weeks gestation, while the combined states of KS, MN, NE and SD averaged only 83.7% of their total abortions prior to 13 weeks gestation. In 1978 Missouri accounted for 33.6% of all abortions performed prior to 13 weeks gestation within the combined five states; yet Missouri accounted for only 19.8% of all abortions within those combined states during the post-12 weeks gestation period. Approximately 910 abortions were prohibited by this in-hospital restriction in Missouri during 1978. *Center for Disease Control Abortion Surveillance, 1978,* U.S. DEPT. H.E.W., November 1980, Table 12 at 41. (Pltfs. Ex. 4 to Defts. Trial on Remand Exhibit A [hereafter "Tr. R. Ex. ____"], T.R. 145, 146).

In 1980 all second trimester abortions performed by the D&E method in Missouri were performed by Truman Medical Center and by plaintiff Reproductive Health Services, an out-patient facility in the St. Louis, Missouri area. (J.A. 175, Henshaw). D&E is an accepted practice for out-patient, second trimester abortion throughout the United States. It is well-recognized as the safest method and it is considered minor surgery. (J.A. 178, Eubanks).

The requirement of mandating hospitalization increases the risks of mortality and of morbidity to women by reason of:

(a) Increased anxiety through greater loss of anonymity and of privacy; and increased anxiety through exposure to a larger number of hospital personnel, who are not screened and/or selected on considerations of their personal acceptance of abortion, thereby exposing patients to adverse judgmental attitudes. These adverse factors are more controllable and occur less frequently in the clinic setting. (T.20, Widdicombe; J.A. 106-07, Kassar; J.A. 120-21, Crist; J.A. 179, Eubanks).

(b) Increased risk of infection and more serious strains of infection present in hospitals than are present in out-patient facilities. (J.A. 100, Widdicombe; T. 131, Palmer; J.A. 107-08, Kassar; J.A. 120-21, Crist; J.A. 179, Eubanks).

(c) Increased use and risks of general anesthesia in hospitals than in clinics. (J.A. 96, Widdicombe; J.A. 106-07, Kassar; J.A. 120, Crist).

(d) Travel necessary to reach a hospital, which adversely impacts women forced to leave their accustomed locales, their families, their natural support systems and their personal physicians. Moreover, travel adversely impacts the treatment of abortion complications which are not immediately present at the time of the procedure; since complication care is best delivered by the performing physician. (T.368-69, Crist; J.A. 181, Eubanks; J.A. 58-59, Cates).

(e) Increased cost burden by $150.00 to $750.00 (J.A. 96, Widdicombe), by $1,000.00 to $1,650.00 (J.A. 102, Palmer), by $1,350.00 to $1,500.00 (J.A. 121, Crist). The average cost of a second trimester, D&E abortion at plaintiff Reproductive Health Services is $260.00. (J.A. 162, Widdicombe). The prevailing out-patient D&E charge in the United States is "$250 to $300." (J.A. 96, Widdicombe).

The increased costs of in-hospital procedures, the delays incurred by reason of hospital and bed availability (J.A. 108-09, Kassar) and the relative risks can not justify this Section on the traditional medical/surgical, cost/benefit ratio evaluaton (T. 389, Kretzschmar). It is a financial burden. (J.A. 187, Eubanks).

(f) Delays engendered by restricted hospital and bed availability. (J.A. 109, Kassar).

(g) Direct interrupton of the traditional doctor-patient relationship. (T.216, Kassar; J.A. 121, Crist; J.A. 126, Kretzschmar).

(h) Direct impediment to the delivery of second trimester abortions. (T.26,28, Widdicombe; T.131, Palmer; J.A. 109, Kassar; J.A. 122, Crist; J.A. 126, Kretzschmar). Defendants' own expert Dr. Schmidt admitted that "(t)he choice of where a procedure is to be performed is traditionally the doctor's responsibility and decision." (J.A. 154).

(i) Increased anxiety increases morbidity and mortality. (J.A. 180-81, Eubanks).

Defendants' own expert witnesses did not dispute any of the above specifics of prevalence, use, infection, anesthesia, anonymity, anxiety, safety and the experience and results as contained in the literature. Rather, they merely stated their personal conclusionary opinions that all second trimester abortions should be performed in a hospital.

The impacts and encumbrances imposed by this requirement fall disproportionately upon certain classes of the abortion patient populations. The increased costs of out-of-state or across-state, in-hospital abortions had nearly eliminated the abortion option for those groups of women who disproportionately seek second trimester abortions: Teenagers and the economically disadvantaged. (T. 132-33, Palmer; T. 214-15, Kassar; T. 415, Kretzschmar; J.A. 186, Eubanks). Twenty-eight percent of plaintiff Reproductive Health Services' patients are under 18 years of age. (J.A. 95, Widdicombe). In Dr. Kretzschmar's practice, as Chair of Obstetrics and Gynecology at both Truman Medical Center and at the University of Missouri Medical School of Kansas City, 65% of the patients are under 18 years of age (J.A. 126) and in plaintiff Dr. Palmer's practice, one-third (J.A. 104).

The adverse effects upon minors, by reason of inherent delays as a result of their relative lack of sophistication and maturity was dramatically evidenced. This results from an "inability of a young woman to accept the fact that she may in fact be preg-

nant." (J.A. 97, Widdicombe). Dr. Kassar indicated that "(t)he first thing the child goes through. It can't happen to me. They deny it. They are scared. And the (*sic*) try to block it." (T. 215).

The burden and interference is also evident when one considers that in 1978, 6,990 Missouri women were forced to obtain abortions outside of the State, while only 2,380 nonresidents obtained abortions in Missouri. (A deficit exchange ratio of 3:1). (J.A. 173-74, Henshaw). In fact, the disparity was even greater due to the actual demographic considerations. (J.A. 177, Henshaw).

The D&E procedure through 15 weeks has a national mortality rate of 4 per 100,000 compared to the Missouri mortality rate for childbirth of 28 per 100,000. (J.A. 106, Kassar). The risk of D&E is 1/10 to 1/20 the risk of childbirth (J.A. 121, Crist). D&E risks equal those of childbirth when D&E is performed at 24 weeks or later (J.A. 179, Eubanks). D&E is the safest method during the first half of the second trimester (12-25 weeks or up to 18½ weeks. (T.31, Widdicombe; T.R. 110-11, Eubanks). Reports in the literature demonstrate that out-patient D&E is safer than all in-hospital non-D&E abortion procedures. (T. 74, Widdicombe; J.A. 101, 103, Palmer). "(C)ertainly, through 16 weeks, . . . D&E abortions outside of hospitals are no more dangerous than D&E abortions performed in hospitals and in many cases are cheaper and more convenient." (J.A. 63,76, Cates).

An out-patient D&E is safer for the patient than the same procedure in-hospital. (J.A. 106, T. 212, Kassar). "It is roughly twice as risky to perform it in a hospital by available statistics versus a free standing clinic." (J.A. 120, Crist). Dr. Palmer testified that "placing a patient in a hospital for a second trimester abortion opens her to more dangers than the abortion itself does." (J.A. 102). Defendants' own expert Dr. Schmidt conceded that the practice of out-patient D&E "is acceptable if it works all right." (J.A. 154). Dr. Schmidt offered no testimony of "it (not working) all right."

There was no evidence of any other Missouri statute mandating a site requirement for any other medical or surgical procedure. Defendants' own expert Dr. Nathanson readily admitted that "(t)he rates for morbidity outside of a hospital are probably no different than the rates in-hospital." (J.A. 144). The actual experience demonstrates that second trimester procedures are safer than first trimester procedures. Plaintiff Reproductive Health Services, comparing 11,190 first trimester procedures with 1,160 second trimester D&E procedures, for the period January 1980 through June 1981, found:

> Total complications by percentage rates (d) were 26.21% higher for first trimester procedures than for second trimester procedures. Total hospitalizations by percentage rates (e) were 94.12% higher for first trimester procedures than for second trimester procedures. Total complications hospitalized by percentage rates were 52.00% higher for first trimester procedures than for second trimester procedures.

Pltfs. T.R. Ex. 2, T.R. 65-66; J.A. 157-60, Widdicombe.

The experience in Louisville, Kentucky, based upon a first trimester experience of 8,465 abortions and a second trimester experience of 7,211 abortions, for the period of 1977 to date, was similar. (T.R. 130, Eubanks).

Dr. Cates in discussing a hypothetical second trimester abortion for his own wife stated, "(m)y method of choice would be a D&E procedure and having it performed in a nonhospital facility". (J.A. 50). Dr. Eubanks testified he would always elect an out-patient D&E procedure for his patients over the same procedure in a hospital. (J.A. 179).

Complications which may arise from a D&E procedure are adequately managed either in the out-patient facility or in a hospital following an appropriate transfer. (J.A. 96, Widdicombe). There is no greater likelihood of a need arising for

blood transfusion during the second trimester procedure than in the first trimester procedure. (J.A. 99, Widdicombe). The incidence of infection, in any case, arises 48-96 hours post-procedure (J.A. 100-01, Widdicombe; J.A. 117-18, Kassar), after the patient has departed "(b)y two to three days" (J.A. 117, Kassar) the facility where the abortion was performed, be it clinic or hospital (T. 72, J.A. 101, Widdicombe).

Defendants offered no testimony demonstrating any adverse effects upon patient care in the numerous jurisdictions wherein second trimester procedures are routinely performed by the D&E method at out-patient facilities, as compared to where they are routinely performed in-hospital. Plaintiffs offered a great deal of testimony based upon actual experience that, in fact, the safety experience is better under the out-patient model as opposed to the in-hospital situation.

During Dr. Eubanks' four years experience with over 7,211 cases of second trimester D&E abortions, in not a single instance of complication did the fact of the abortion being an out-patient procedure (as opposed to being performed in- hospital) adversely affect the timing, course, nature, or ultimate outcome of the treatment of that complication. (J.A. 182; T.R. 122).

While two-thirds of D&E procedures are performed outside of hospitals (J.A. 46, Cates), "D&E's performed in nonhospital settings appear to have no greater risk than those performed in hospitals." . . . "It was no safer to have their D&E procedures performed in the hospital than it was to be performed at the clinic." (J.A. 47, Cates).

Post-complication care is best rendered by the same physician who performed the abortion. (T.R. 131-33, Eubanks). There is greater likelihood of the abortion physician being the complication treating physician in the clinic situation, than where the abortion was performed in the hospital. (J.A. 58-59, Cates).

When the treatment of complications is under review, "it's the threshold of recognition of the physician that's important, rather than the availability of products." (J.A. 66, Cates). Dr. Crist who practices in Kansas indicated that "forty-five percent of my second trimesters are referred from the State of Missouri." (J.A. 124).

The requirement of in-hospital does not in any manner ensure quality care, for the quality of hospitals ranges from good to bad, as does the quality of physicians. (T.R. 36-37, Widdicombe; J.A. 74-75, Cates). A blanket in-hospital requirement after 12 weeks does not "insure any greater degree of health and safety for women." "I do not believe that D&E's performed in nonhospital settings are inherently more dangerous than those performed in hospitals." (J.A. 76; Defts. Tr.R. Ex. A, T.R. 145, 146, 119). In light of the fact that over 75% of all second trimester abortions in Missouri are performed by D&E, Dr. Cates considered the 12 week threshold of in-hospital not "to be rationally related to maternal health" and, in fact, to be "very irrational." (Defts. Tr.R. Ex. A, T.R. 145, 146, 121, 128). The fact that hospitals are better equipped to handle the complications is not "synonymous with the fact that they handle them better if the original procedure is performed there as opposed to being performed in a clinic." (T.R. 32, Widdicombe).

Although one hospital in the State of Missouri does perform D&E second trimester abortions (Truman Medical Center in Kansas City, Missouri [J.A. 103, Palmer; J.A. 112, Kassar; J.A. 51-57, Schramm; J.A. 73, Stipulation of parties]); in fact, in-hospital second trimester abortions, by any method, are not readily available in Missouri. In addition to Truman Medical Center, one other Missouri hospital reported doing one second trimester abortion (by a method other than D&E) in each of the years 1979 and 1980 and one other Missouri hospital reported doing three second trimester abortions (by a method other than D&E) in each of the years 1979 and 1980. (J.A. 170, Henshaw).

As the testimony indicated, these cases were apparently considered first trimester procedures before being commenced, but were later properly classified as second trimester procedures following the post-abortion examination of the uterine contents. (J.A. 170-71, Henshaw). (Cross-Pet. A-116 at n.3).

The Missouri abortion rate per 1,000 women is approximately one-half the national rate. (J.A. 172-73, Henshaw). The national per state percentage of total abortions performed in-hospital is nine per cent. The rate for Missouri in 1980 was seven per cent, and in 1979 (when only hospitals performed second trimester procedures) the rate was three per cent. (J.A. 171, 174, Henshaw). Of all second trimester abortions in Missouri in 1979, 540 were in-hospital and 690 were in-clinic. (J.A. 169, Henshaw). The provision by plaintiff Reproductive Health Services of second trimester D&E procedures in 1980 did not detract from the same service previously offered only in-hospital by Truman Medical Center. In fact, the volume of Truman Medical Center in 1980 increased over its 1979 volume. Reproductive Health Services drew entirely from the existing pool of unmet need. (J.A. 175, Henshaw). In 1979 only 540 second trimester abortions were performed in Missouri. In 1980 the number increased 157% to 1,390. (J.A. 169, Henshaw).

If all abortions performed by Missouri hospitals were second trimester abortions, the unmet need for such services in Missouri still would remain unsatisfied. (J.A. 174, Henshaw). The performance by a particular facility of all abortion requests made to it is in no manner synonymous with meeting the need or fulfilling total availability. (J.A. 176-77, Henshaw). Only 34% of the need in Missouri for second trimester abortions is presently being met, although this is almost three times the 13% of the need met in 1979 (when only hospitals provided such services). (J.A. 171-72, Henshaw). "(R)egulations requiring abortions being performed in hospitals * * * had the effect of limiting the availability of second-trimester procedures" (J.A.

48, Cates); for "women who had to travel are less likely to obtain abortions." (J.A. 77, Cates). In Missouri, 49% of fertile women live in counties without any abortion provider. Nationally, the same figure is 25% or less. (J.A. 174, Henshaw).

II.

The Second Physician Requirement (MO. REV. STAT., § 188.030.3)

Section 188.030.3 imposes a requirement that a second physician be in attendance at all abortions of post-viable fetuses. The testimony of plaintiffs' expert witnesses, as well as many of defendants' witnesses, was that in certain methods of abortion on viable fetuses there is absolutely no reason for a second physician to attend, because for such methods there exists no possibility of fetal survival and for other such methods the chances of fetal survival are extremely remote. (J.A. 113, Kassar; J.A. 123, Crist; J.A. 127, Kretzschmar). Defendants' own experts agreed. (J.A. 143, Nathanson; J.A. 154, Schmidt; Defts' Tr. Ex. Q at 76-77, J.A. 43, Martin). "(T)here is a greater need for a second physician in term deliveries than there are (*sic*) in the cases of abortion by prostaglandin and saline." (J.A. 124, Crist).

The cost of a second physician in attendance would be a direct burden upon the availability and delivery of abortion services (J.A. 110, Kassar; J.A. 124, Crist; J.A. 128, Kretzschmar) and would be an aberration of the traditional doctor-patient relationship. (T. 226, Kassar; J.A. 124, Crist; J.A. 128, Kretzschmar). No other Missouri statute exists requiring two doctors in attendance for any other medical or surgical procedure, no matter how grave or risky. (T. 357, Crist). Two doctors are not required either for normal childbirth or for the delivery of a premature infant. (J.A. 106, Palmer; J.A. 110, Kassar; J.A. 123-24, Crist; J.A. 127, Kretzschmar). The delivery of "premature children without the attendance in the operating

room of a second physician * * * (e)xcept in large university settings, * * * is the rule in this country." (J.A. 123-24, Crist). In fact, the newborn is the sole responsibility of the delivering obstetrician, until he or she chooses to relinquish that responsibility to the neonatologist, pediatrician or other appropriate medical personnel. (J.A. 133, Crist). No exception is made for the performance of such abortion without the second physician in attendance, although immediate emergency circumstances might well warrant the same.

III.

The Pathology Requirement
(MO. REV. STAT., § 188.047)

Section 188.047 imposes a requirement of an examination of all abortion tissue by a certified pathologist at all stages of pregnancy. No disputed testimony was given by either plaintiffs' or defendants' witnesses as to the fact that no guidance is given as to whether the required examination by the certified pathologist is to be merely a gross (visual) or a microscopic examination. (J.A. 99, Widdicombe; T. 150, Palmer; J.A. 110-11, Kassar; J.A. 124, Crist; J.A. 128, Kretzschmar; J.A. 155, Schmidt; J.A. 134-35, Smith; J.A. 150, Keitges). Normally, pathology referral is medically indicated for only 12% of abortion cases, following a thorough gross examination by the performing physician. (J.A. 97-98, T. 100, Widdicombe; J.A. 104, Palmer; J.A. 111, Kassar; J.A. 125, Crist; J.A. 128, Kretzschmar).

Plaintiffs' expert witness, Dr. J. Chandler Smith, Chairman of the Department of Pathology at the University of Missouri Medical School at Kansas City and at Truman Medical Center, testified that there are two major reasons for a gross exam: the presence of molar or other irregular tissue and the existence of an extra-uterine pregnancy. He testified that these are capably

accomplished by the performing physician's gross examination, which is as competent as a gross exam by a certified pathologist. (J.A. 135). A gross examination by the performing physician will reveal the presence or non-presence of a uterine pregnancy and/or of a blighted ovum. (J.A. 98, Widdicombe). Dr. Smith indicated that molar tissue occurs in approximately one of every 2,000 cases and an extra-uterine pregnancy in approximately one of every 250-300 cases (J.A. 135). In both situations, Dr. Smith indicated the performing physician would note the irregularity in all cases and routinely forward those samples to the pathologist. (Tr. 467-68).

All of plaintiffs' experts agreed that this Section, when evaluated on the cost/benefit ratio analysis used for evaluating the appropriateness of all medical tests, could not be justified. (J.A. 105, Palmer; J.A. 112, Kassar; T. 400, Kretzschmar). Defendants' expert pathologist Dr. Keitges admitted that many hospitals routinely do not require pathology examinations of tissue, including tonsils, hernias, hemorrhoids, *etc.* (J.A. 146). Witnesses agreed that the sending of tissue to pathology has traditionally been the province of the attending physician. (J.A. 99, Widdicombe; J.A. 105, Palmer; J.A. 111, Kassar; T. 372, Crist; J.A. 129, Kretzschmar). Defendants' expert pathologist agreed (J.A. 151, Keitges), as did defendants' expert Dr. Schmidt (T. 846). They agreed that the additional cost factor involved would substantially burden the availability and delivery of abortion services. (T. 51, Widdicombe; J.A. 105, Palmer; J.A. 111-12, Kassar; J.A. 125, Crist; J.A. 129, Kretzschmar). The cost of each examination would be $20 to $35 (J.A. 99, Widdicombe); $20 to $80 (J.A. 105, Palmer); more than $30 (J.A. 111, Kassar); "at least $40.00 per examination" (J.A. 125, Crist); "around $25.00" (J.A. 128, Kretzschmar). Defendants' expert estimated $35 or $37.50. (J.A. 151, Keitges).

This section unwarrantedly applies to all stages of pregnancy and does not require any time limits for the pathologist's ex-

amination to be conducted; thereby obviating entirely the extremely minimal reasons for the same. "(I)f I send it to the pathologist, they are going to come late and not going to help me. By the time they come back, I have already seen the complication." (J.A. 111, Kassar).

Plaintiffs' experts also testified that such a requirement was not common medical practice in abortion cases in the United States. (J.A. 99, Widdicombe; J.A. 105, Palmer). Defendants' expert Dr. Schmidt agreed. (J.A. 153). Defendants' expert pathologist Dr. Keitges conceded Dr. Smith's expertise (T. 754-55), conceded that the individual physician traditionally decides which tissue is to be forwarded to pathology (J.A. 151) and conceded that the cost/benefit ratio is an appropriate method of evaluating this Section's rationality (J.A. 151).

Dr. Crist more explicitly related the federal government's experience as reported by the Center for Disease Control, U.S. Department H.E.W. During the five year period of 1972 through 1976, when over 3,800,000 first trimester abortions were performed; only two deaths from ectopic pregnancies resulted which reasonably could have been prevented from the nationwide adoption of this Section. The cost of each life saved would have been $76,000,000.00. (J.A. 132-33, Crist). No other Missouri statute exists requiring pathology on any specific type of tissue. (T. 150, Palmer; T. 237, Kassar; T. 372-73, Crist).

IV.

The Award Of Attorneys' Fees And Costs

Defendants' score card of issues won and lost finds plaintiffs to have batted .500. (Defts. Br. 48). Not only have defendants played free and loose in keeping score, but their analysis of the importance of such wins and losses is highly questionable. (Defts. Br. 47).

Plaintiffs suggest a more accurate scoring would reflect the following.

§ 188.020 - Won - Statutory construction by the District Court awarded plaintiffs the relief sought.

§ 188.025 — Won

§ 188.028 — Lost

§ 188.030 — Won

§ 188.030.1 — Won — Statutory construction by the Appellate Court awarded plaintiffs the relief sought.

§ 188.030.2 — Won — Statutory construction by the Appellate Court awarded plaintiffs the relief sought.

§ 188.030.3 — Won

§ 188.039 — Won

§ 188.047 — Won

§ 188.052 — Won — Statutory construction by the

Appellate Court awarded plaintiffs the relief sought.

§ 188.063 — Won.

It must also be observed that with rare exception, all of both plaintiffs' and defendants' witnesses were expert witnesses; and each testified as to each challenged Section. There exists no feasible nor realistic manner in which time devoted before, during or after trial to any witnesses testimony could be accurately apportioned as to distinct issues. Nor is general preparation time, trial time or post-trial time apportionable on an issue-by-issue basis. The entire Transcript and Transcript on Remand make these conclusions self-evident.

SUMMARY OF ARGUMENT

The Applicable Standards Of Review

The clear and explicit standards for legislative restrictions on abortion established in *Roe* v. *Wade,* 410 U.S. 113 (1973) and *Doe* v. *Bolton,* 410 U.S. 179 (1973) have been consistently applied for ten years. They have proven successful in practice. To alter them now in any fashion permitting greater statutory intrusion into this realm of privacy would be unwarranted and recreate catastrophic affects upon the health of women.

I.

The In-Hospital Requirement (MO. REV. STAT., § 188.025)

The in-hospital requirement for post-first trimester abortions falls by reason of defendants' utter failure to show any rational reason for its enactment. Defendants failed to demonstrate that the health considerations of women are enhanced by such a requirement and, in fact, the evidence was to the contrary. Such a requirement imposes a severe limitation on access to abortion availability by reason of the near total lack of hospital services and the increased expenses incurred.

II.

The Second Physician Requirement (MO. REV. STAT., § 188.030.3)

Requiring the presence of a second physician during the abortion of any viable fetus is irrational and overbroad, when the method of abortion utilized can not possibly result in a live birth.

III.

The Pathology Requirement (MO. REV. STAT., § 188.047)

The requirement of pathology on all abortion specimens at all stages of pregnancy is supported by neither compelling nor rational reasons. This is particularly true, since the Section does not require the type of examination calling for a pathologist's expertise, does not comport with medical practice in the field of abortion or medicine in general, increases unnecessarily the cost of the abortion and serve no justifiable medical purpose.

IV.

The Award Of Attorneys' Fees And Costs

The awards below of fees and costs were wholly consistent with the legislative history and judicial interpretations of Title 42, U.S.C., § 1988.

The allocation of fees on the basis of issues or theories won or lost does not fulfill the purposes of the Act, discourages a full and adequate prosecution of a civil rights action, and, in many cases such as the instant matter, is incapable of application by reason of the nature of the issues, the evidence adduced, witnesses called and testimony taken.

ARGUMENT

The Parties' Witnesses

Plaintiffs' expert witnesses at the initial trial were all either plaintiffs themselves or from the metropolitan Kansas City or St. Louis, Missouri areas. All had extensive experience in the provision of abortion services, both in the numbers of experiences and the length of years covering their involvement. All believed in a female patient's fundamental right, in consultation with a physician, to determine the advisability of terminating a given pregnancy based upon her individual medical circumstances, and her individual moral and religious beliefs. All believed in the freedom and discretion of the individual physician to determine in each case the methodology of delivering abortion services, based upon the particular circumstances, and the physical and psychological health needs and interests of each patient.

Plaintiffs' Expert Witnesses In Order Of Testimony

JUDITH A. WIDDICOMBE, R.N. - Executive Director since its founding in 1973 of Reproductive Health Services, the largest abortion provider in the State of Missouri; Private medical consultant; Medical/surgical clinic management specialist for Planned Parenthood Federation of America, Inc.; Past President of the National Abortion Federation; Member of the Board and Executive Committee of the National Abortion Rights Action League; Member of the American Public Health Association, the Association of Planned Parenthood Physicians, the American Association of Sex Educators, Counselors & Therapists and the Missouri Association of Public Health. (T. 5-7).

ALLEN S. PALMER, D.O. - Member of the American College of Osteopathic Obstetricians and Gynecologists, American

Osteopathic Association, St. Louis Osteopathic Society and Missouri Osteopathic Society; Practicing obstetrician and gynecologist; Teaching assistant and instructor in obstetrics and gynecology; Experienced in having performed 12,000 to 15,000 abortion prcedures. (T. 117-20).

NAIM S. KASSAR, M.D. - Board eligible for the American College of Obstetricians and Gynecologists; Licensed and practicing physician in Missouri and Kansas; Assistant Professor in Obstetrics and Gynecology at the University of Missouri Medical School at Kansas City; Author of numerous articles in the field; Experienced in having performed 7,200 first trimester abortion procedures and over 1,000 second trimester abortion procedures. (T. 199-201).

ELIZABETH M. SMITH, Ph.D. - Assistant Professor, Department of Psychiatry, Washington University Medical School; Adjunct Assistant Professor, George Warren Brown School of Social Work, Washington University; Author of numerous articles in the field; Experienced in having counseled hundreds of women with problem and/or unwanted pregnancies. (T. 288-91, 295).

ROBERT D. CRIST, M.D., Ph.D. - Faculty member of the University of Kansas School of Medicine, appointments in the Departments of Obstetrics and Gynecology and Biochemistry; Licensed physician in Kansas and Missouri; Board certified by the American College of Obstetricians and Gynecologists; Author of numerous articles in the field; Experienced in having performed 10,000 first trimester abortion procedures and 10,000 second trimester abortion procedures. (T. 326-30).

ROBERT M. KRETZSCHMAR, M.D. - Professor and Chairman, Department of Obstetrics and Gynecology at both the University of Missouri Medical School at Kansas City and at Truman Medical Center; Board certified by the American College of Obstetricians and Gynecologists; Author of numerous articles in the field; Experienced in having performed 2,000 first

trimester abortion procedures and 1,000 second trimester abortion procedures. (T. 378-81).

ENRIQUE VERA, M.D. - Board certified by the American College of Psychiatry; Associate Professor of Psychiatry at the University of Missouri Medical School at Kansas City; Associate Director of Training and Director of Emergency Services at Western Missouri Mental Health Center. (T. 442-44).

J. CHANDLER SMITH, M.D. - Chairman of the Department of Pathology at the University of Missouri Medical School at Kansas City and at Truman Medical Center; Board certified by the American College of Pathology; Author of numerous articles in the field. (T. 463-65).

WAYNE SCHRAMM - Director of the Bureau of Health Data Analysis, Missouri Center for Health Statistics, Division of Health, Missouri Department of Social Services, Jefferson City, Missouri. (T.R. 49).

STANLEY HENSHAW, Ph.D. - Senior Research Associate of The Alan Guttmacher Institute, New York City, New York and Washington, D.C. (T.R. 66).

SAMUEL G. EUBANKS, JR., M.D. - Board Certified by the American Board of Obstetrics and Gynecology; Licensed physician and surgeon in Kentucky, Ohio, Tennessee and California; Practicing obstetrician and gynecologist; Experienced in having been involved in an office practice of 15,500 first and second trimester abortions. (T.R. 108-10).

Defendants' expert witnesses were from New Orleans, Cincinnati, New York, Ottawa, Columbia, and St. Louis, as well as Kansas City. None had any extensive experience with the delivery of abortion services or with abortion patients. Most were morally opposed to abortion and most equated abortion with murder. (T. 491-92, Ketterman; T. 570-71, Petruso; T.

702, Dickey; T. 737, James). Many of the defendants' own witneses opposed the arbitrary nature of many of the challenged Sections for a variety of reasons, *infra*, and many of defendants' witnesses had difficulty understanding the intent of specific Sections, *infra*.

The Applicable Standards Of Review

The oft-quoted summation by this Honorable Court in its landmark decision of *Roe* v. *Wade*, 410 U.S. 113 (1973) is explicit and exacting as to what states may and may not do to regulate the medical procedure of abortion.

> (a) For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.
>
> (b) For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interests in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.
>
> (c) For the stage subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment for the preservation of the life or health of the mother.

Roe, supra, 410 U.S. at 164-65.

This unequivocal standard has never been altered by the High Court. Its message was repeated again and again throughout the two companion cases of *Roe, supra*, and *Doe* v. *Bolton*, 410 U.S. 179 (1973), which "of course, are to be read together." *Roe, supra*, 410 U.S. at 165. See *Roe, supra*, at 162-64 and *Doe, supra*, at 194-95.

> Georgia may . . . from and after the end of the first trimester, adopt standards for licensing all facilities where abortions may be performed so long as those standards are legitimately related to the objective the State seeks to accomplish.

Ibid.

Since 1973, various federal courts of appeal have been called upon to interpret and to apply these standards. They have done so with complete uniformity and clarity of understanding.

The Seventh Circuit has discussed in detail the nature and responsibilities of the burden in the abortion litigation context.

> It is well-settled that a regulation that interferes with the woman's right to decide whether to bear a child must be narrowly drawn to express only the legitimate State interest at stake . . . Of course, a law is not considered an interference with the pregnancy termination decision and subject to strict scrutiny simply because it concerns abortion. In *Maher* v. *Roe,* 432 U.S. 464 (1977) . . ., for example, the Supreme Court applied the rational basis test to a law that merely implemented a State's preference for childbirth over abortion without adding any "restriction on access to abortion that was not already there." 432 U.S. at 474 . . . In applying the rational basis test under those circumstances, however, the Court in *Maher* emphasized that it was not retreating from its holding in *Roe* v. *Wade:* "There is a basic difference between direct state interference with a protected activity consonant with legislative policy." *Id.* at 475 . . . Thus, to trigger strict scrutiny of S.B. 47, it is the plaintiffs' burden to demonstrate only that it is a "direct interference" with the abortion decision or imposes restrictions that did not already exist . . . The threshold question whether there is a "burden" or "direct interference" in the pregnancy termination decision requires the plaintiff merely to show the

> requisite degree of interference. If the interference is sufficiently substantial and not de minimis, the State has to show the compelling basis for the law, that is, that the burden is not "undue" or unjustifiable . . . The decisions of the Supreme Court do not permit us to substitute what is no more than a standardless reasonableness test urged by the defendants for the well-established requirement that the State justify the impact of a law on this fundamental right by a demonstrable compelling interest.

Charles v. *Carey,* 627 F.2d 772, 776-78 (7th Cir. 1980). The *Charles* concept of undue burden has been accepted by many Circuits and rejected by none. *See Planned Parenthood Association of Kansas City, Missouri, Inc.* v. *Ashcroft,* 655 F.2d 848, 855 (8th Cir. 1981), *cert. granted,* 50 U.S.L.W. 3934 (May 24, 1982); *Deerfield Medical Center* v. *City of Deerfield Beach,* 661 F.2d 328, 335 (5th Cir. 1981); *Akron Center for Reproductive Health, Inc.* v. *City of Akron,* 651 F.2d 1198 (6th Cir. 1981), *cert. granted,* 50 U.S.L.W. 3934 (May 24, 1982).

In the recent decision of *Women's Medical Center of Providence, Inc.* v. *Roberts,* 530 F.Supp. 1136 (D.R.I. 1982), Chief Judge Pettine carefully and thoughtfully examined in great detail the conflicting views engendered since *Roe* and *Doe* on the extent of permissible regulation. Although lengthy, his apposite discussion is set forth in full, inasmuch as it is the most thorough and comprehensive review of the very issue which is the crux of this appeal.

The Legal Standard

> Before discussing each requirement of the Rhode Island statute, it is necessary that I establish the applicable legal standard. This standard was first established in *Roe* v. *Wade,* 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973), and *Doe* v. *Bolton,* 410 U.S. 179, 93 S.Ct. 739, 35 L.Ed.2d 201 (1973), and further expounded in *Planned Parenthood*

of Central Missouri v. *Danforth*, 428 U.S. 52, 96 S.Ct. 2831, 49 L.Ed.2d 788 (1976), and *Harris* v. *McRae*, 448 U.S. 297, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980). These cases hold that a woman's right to decide whether or not to terminate her pregnancy is a fundamental right, bound up with the rights of privacy implicit in the "liberty" component of the due process clause of the Fourteenth Amendment. Hence, only compelling state interests can justify any state limitations. *Roe* v. *Wade*, *supra*, 410 U.S. at 155, 93 S.Ct. at 727; *Akron Center for Reproductive Health, Inc.* v. *City of Akron*, 479 F.Supp. 1172, 1200 (N.D.Ohio 1979), *aff'd in part, rev'd in part*, 651 F.2d 1198 (6th Cir. 1981). *See Planned Parenthood League of Massachusetts* v. *Bellotti*, 641 F.2d 1006, 1016 (1st Cir. 1981) ("[W]ithout deciding whether the interest asserted has been shown to be compelling, we conclude that the state has failed to establish that the [statutory provision] is 'necessary' to serve that interest.") However, certain insignificant or *de minimis* burdens on the right are permissible and will not trigger strict scrutiny of the relevant enactment. *Charles* v. *Carey*, 627 F.2d 772, 777 (7th Cir. 1980).[1]

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[1] I agree with the Seventh Circuit that the concept of "undue burden" used by the Supreme Court in analyzing some recent cases involving alleged restrictions on the right to an abortion causes some confusion regarding the standard to be applied in cases involving first trimester restrictions. *See Charles* v. *Carey*, 627 F.2d 772, 777-78 (7th Cir. 1980). The confusion appears to stem from attempts to reconcile the position taken by the Court in *Roe* v. *Wade*, which arguably holds that there are no compelling state interests that ever justify a state-imposed burden on the right to a first trimester abortion, with the Court's position in *Danforth* that limited informed consent requirements may be imposed by the state during the first trimester, and with its position in *Maher* v. *Roe*, 432 U.S. 464, 97 S.Ct. 2376, 53 L.Ed.2d 484 (1977) and *Harris* v. *McRae*, 448 U.S. 297, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980), that the state may discourage indigents from exercising their right to an abortion by refusing to pay for the procedure. Contrary to the clear indications in *Wade* and *Bolton*, the Court in its later cases has allowed some state enactments that regulate the first trimester abortion decision.

(Footnote 1 continued)

Two approaches have emerged as lower federal courts have struggled with the line of Supreme Court abortion decisions. One approach focuses on some Supreme Court language to the effect that if a regulation does not "unduly burden" the first trimester decision, it will be upheld. *See Maher* v. *Roe,* 432 U.S. at 473, 97 S.Ct. at 2382; *Bellotti* v. *Baird,* 428 U.S. 132, 147, 96 S.Ct. 2857, 2866, 49 L.Ed.2d 844 (1976). Courts taking this approach conclude from this language that the first inquiry to be undertaken is whether a law "unduly burdens" a woman's right to an abortion. If this threshold determination of undue burden is met, then strict scrutiny applies; if not, the state's justification need only meet the rational relationship test. *See Akron Center for Reproductive Health, Inc.* v. *Akron,* 479 F.Supp. 1172, 1200 (N.D.Ohio), *aff'd in part, rev'd in part,* 651 F.2d 1198 (6th Cir. 1981); *Women's Community Health Center, Inc.* v. *Cohen,* 477 F.Supp. 542, 545 (D.Me.1979).

The second approach stems from a different perspective. In these cases, the courts determine whether the law or regulation imposes a significant or non-*de minimis* burden on the woman's exercise of her fundamental right. If such a burden is not imposed by the regulation, then the law need satisfy only the relaxed standard of reasonableness. However, if a sufficient degree of interference with the abortion decision can be shown, the regulation has to be supported by a compelling state interest and must be narrowly tailored to serve that interest. *See, e.g., Akron Center for Reproductive Health, Inc.* v. *Akron,* 651 F.2d 1198, 1204 (6th Cir. 1981); *Planned Parenthood League of Mass.* v. *Bellotti,* 641 F.2d 1006, 1014-15 (1st Cir. 1981); *Charles* v. *Carey,* 627 F.2d 772, 777 (7th Cir. 1980). I believe that the latter approach represents the better approach in reviewing these statutes. I am persuaded by the reasoning of the Seventh Circuit in *Charles* v. *Carey:*

> [T]he term "undue burden" defines the ultimate constitutional issue, not merely the threshold requirement for strict scrutiny. When describing specifically the burden of the party challenging a state regulation, the Supreme Court has not used the term "undue" .... The threshold question whether there is a "burden" or "direct interference" in the pregnancy termination decision requires the plaintiff merely to show the requisite degree of interference. *If the interference is sufficiently substantial and not de minimis, the State has to show the compelling basis for the law, that is, that the burden is not "undue" or unjustifiable.*
>
> 627 F.2d at 777 (citations omitted). (Emphasis supplied).

Balancing a woman's rights against the state interests, the Supreme Court has divided pregnancy into three trimesters. During the first trimester, no non-*de minimis* burdens on the abortion decision have been permitted. *See Colautti* v. *Franklin,* 439 U.S. 379, 387, 99 S.Ct. 675, 681, 58 L.Ed.2d 596 ("[U]p to the points where important state interests provide compelling justifications for intervention, 'the abortion decision in all its aspects is inherently, and primarily, a medical decision....'"). During the first three months, once the decision is made, the state cannot interfere with its effectuation, except to enhance, in a very limited and nonburdensome way, the medical aspects of the patient-physician decision-making process. *See Planned Parenthood of Central Missouri* v. *Danforth, supra,* 428 U.S. at 67, 81, 96 S.Ct. at 2840, 2846 (upholding a minimal informed consent requirement that applied to the first trimester and a record-keeping requirement that applied to all abortions regardless of trimester because the Court found "no legally significant impact or consequence on the abortion decision or on the physician-patient relationship"). When a woman reaches the second trimester of pregnancy, the state "in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways reasonably related to maternal health." *Roe* v. *Wade, supra,* 410 U.S. at 164, 93 S.Ct. at 732. Finally, the third trimester of pregnancy has been characterized by the Supreme Court, for purposes of constitutional analysis, as "viability." At this point the state "in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary" to preserve the life of the mother. *Id.* at 164-65, 93 S.Ct. at 732.

Because the Rhode Island statute does not differentiate among trimesters, the appropriate standard of review is that applicable to the first trimester. *See, e.g., Women's*

Services P.C. v. *Thone,* 483 F.Supp. 1022, 1044 (D.Neb. 1979), *aff'd per curiam,* 636 F.2d 206 (8th Cir. 1980), *vacated and remanded,* 452 U.S. 911, 101 S.Ct. 3043, 69 L.Ed.2d 414 (1981). Thus, if the statute creates a substantial, non-*de minimis* interference with a woman's right to an abortion, Rhode Island must demonstrate a compelling state interest to justify the interference. *See* note 5 *supra.*

The outside parameters of what a state may do during the first trimester have been set. For example, in *Danforth* the Supreme Court upheld the *de minimis* interference created by minimal informed consent and record keeping, which did not obstruct a meaningful physician-patient consultation and did not seek to influence the outcome of the woman's final decision. (I note, however, that the Court found that even these requirements "approach[ed] impermissible limits." *Danforth, supra,* 428 U.S. at 81, 96 S.Ct. at 2846.) Furthermore, in *Maher* v. *Roe, supra,* 432 U.S. at 473-74, 97 S.Ct. at 2382, and *Harris* v. *McRae, supra,* 448 U.S. at 315-16, 100 S.Ct. at 2687-88 the Court declared that states could constitutionally refuse to pay for both non-therapeutic and medically-necessary abortions. The Supreme Court reasoned that these kinds of budgetary decisions simply place no governmental obstacle in the path of a woman who chooses to terminate her pregnancy.

Having analyzed these and other cases establishing the limits of state interference with the abortion decision, I find that most of the Rhode Island statute exceeds these limits. As I read the statute at issue, it clearly imposes legally significant, non-*de minimis* burdens on the right of a woman, in consultaton with her physician, to decide to terminate her pregnancy. Furthermore, the state has not shown a compelling interest to justify its intrustion.

530 F.Supp. 1103-04.

Each and every direct interference or burden mandates the application of a strict judicial scrutiny standard of review, whenever a fundamental right, such as abortion, is being impeded.

> . . . it is the character of the right, not of the limitation, which determines what standard governs the choice.

Thomas v. *Collins,* 323 U.S. 516, 530 (1945). *See Schad* v. *Borough of Mount Ephraim,* 452 U.S. 61, 68 (1981).

The need for uniformity and clarification in a major area of the law was decisively met by this Honorable Court in *Roe* and *Doe.* Those opinions have been consistently interpreted by Appellate Courts in near parallel fashion. To alter in any radical or dramatic fashion the state of the law and constitutional facets of abortion as they have been interpreted and applied for 10 years, would be injudicious and unwise. Such ruling would run opposite to the judicial rationale underlying *United States* v. *Ross,* 50 U.S.L.W. 4580 (1982), involving a different area of privacy and criminal law than the areas presently before this Honorable Court.

> It is well settled that, quite apart from the guarantee of equal protection, if a law "impinges upon a fundamental right explicitly or implicitly secured by the Constitution (it) is presumptively unconstitutional." *Mobile* v. *Bolden,* 446 U.S. 55, 76 *(plurality opinion).*

Harris v. *McRae,* 448 U.S. 297, 312 (1980).

I.

The In-Hospital Requirement (MO.REV.STAT., § 188.025)

In *Roe, supra,* this Honorable Court held that in the second trimester of pregnancy the state may regulate abortion for the reasonable protection of maternal health. This ruling was based on the finding that, at the time of the decision in 1973, second trimester abortions were as dangerous as childbirth.

> With respect to the State's important and legitimate interest in the health of the mother, the "compelling" point, in the light of *present medical knowledge,* is at approximately the end of the first trimester. *This is so because of the now established medical fact, . . . that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth.* It follows that, from and after this point, a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health.

410 U.S. at 163. (Emphasis supplied).

Today, it is undisputed "present medical knowledge" that the D&E technique up to eighteen weeks is at least twice as safe as childbirth. All of plaintiffs' experts as well as many of defendants' experts acknowledged that the D&E procedure was relatively unknown and unused in the United States in 1973. (J.A. 95, Widdicombe; J.A. 120, Crist; J.A. 126, Kretzschmar). (Defendants' experts: J.A. 144, Nathanson; J.A. 154, Schmidt).

This Honorable Court in *Roe* noted the then existing position of the American Public Health Association, which recommended that second trimester abortions be performed in hospitals. *Id.* at 145. With the advent of medical advances and experience, the American Public Health Association contrary to its policy originally articulated in 1970, currently provides as its policy:

> Current data show that abortions occurring in the second trimester can be safely performed by the Dilatation and Evacuation (D and E) procedure. D and E procedures are shown to be far safer than saline or prostaglandin instillation. Requirements that all abortions after 12 weeks of gestation be performed in hospitals increase the expense and inconvenience to the woman without contributing to the safety of the procedure.

APHA Recommended Program Guide For Abortion Services (Revised 1979), AMERICAN JOURNAL OF PUBLIC HEALTH, Vol. 70, No. 6, June, 1980 at 652, 654.

The American College of Obstetricians and Gynecologists has also deemed it appropriate to eliminate their recommendation of an in-hospital requirement for second trimester procedures, originally formulated in 1974. *See Manual of Standards for Obstetrical-Gynecological Services of the American College of Obstetricians and Gynecologists* (1982), p. 16, providing for out-patient abortion services through 18 weeks.

The in-hospital second trimester requirement was deleted by Planned Parenthood Federation of America, Inc. for its 182 affiliates (T. 6, Widdicombe) in the publicaton of its *Abortion Services in Planned Parenthood Affiliates* (December 15, 1977).

The standard to be applied to this Section is whether it has the effect of "substantially limiting access to the means of effectuating that decision." *Carey* v. *Population Services International,* 431 U.S. 678, 688 (1977). The clear answer is yes.

What was found true for contraceptive providers in *Carey* is equally true for abortion providers.

> The burden is, of course, not as great as that under a total ban on distribution. Nevertheless, the restriction of distribution channels to a small fraction of the total number of possible retail outlets renders contraceptive devices considerably less accessible to the public, reduces the opportunity for privacy of selection and purchase, and lessens the possibility of price competition.

431 U.S. at 689.

In *Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52 (1976), this Honorable Court struck down a Missouri statute, which prohibited the use of the saline abortion technique after the first trimester. This High Court strictly scrutinized

the restriction and reversed the findings of the District Court, which had concluded that the restriction was reasonably related to maternal health, since it had found two other techniques (mechanical means of inducing abortion and prostaglandin) to be safer than saline. 428 U.S. at 77.

This Honorable Court refused to defer to the Missouri legislative finding. Instead, this Court pointed to several important factors, including the wide medical acceptance of saline instillation as an abortion method, the relative unavailability of the alternative techniques and the higher risk of maternal death with the other available choices. *Id.* at 77-79. These factors said this Court, showed that the Missouri statute bore no reasonable relation to the preservation and protection of maternal health. Rather:

> The State . . . would prohibit the use of a method which the record shows is the one most commonly used nationally by physicians after the first trimester and which is safer, with respect to maternal mortality, than even continuation of the pregnancy until normal childbirth. Moreover, as a practical matter, it forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed.

428 U.S. at 78-79.

This Court stressed the unavailability of prostaglandin in Missouri as central to its consideration of the effect of the regulation on maternal health.

> . . . the outright legislative proscription of saline fails as a reasonable regulation for the protection of maternal health. It comes into focus, instead, as an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting, the vast majority of abortions after the first 12 weeks. As such, it does not withstand constitutional challenge.

428 U.S. at 79.

This Court's criteria and rationale then, are entirely analogous here to the out-patient prohibition for second trimester procedures.

Defendants have utterly failed to meet their burden of proving that this restriction is narrowly tailored to promote the maternal health of women in Missouri. In fact, the proof and testimony was that this Section has in the past caused them irreparable harm. Defendants not only failed to satisfy their burden that this restriction was a narrowly tailored one, they presented no rebuttal whatsoever to plaintiffs' overwhelming documentary and testimonial evidence, other than by way of ultimate, unsubstantiated conclusions from their own witnesses. For these reasons, the Trial Court's decision voiding this Section must be affirmed.

Even defendants' experts had difficulties with this Section, Dr. Martin would have started its applicability "at thirteen weeks." (Defts. Ex. Q. at 8). Dr. Nathanson readily admitted that "(t)he rates for morbidity outside of a hospital are probably no different than the rates in-hospital." (J.A. 144).

Defendants have failed to refer this Honorable Court to a single line of testimony or shred of evidence that the in-hospital procedure has *in practice* been shown to be safer than the out-patient procedure; or a single experience in which an out-patient complication resulted in greater adverse effects upon the patient than would have occurred had the same complication arisen originally within a hospital confines. Instead, defendants unsuccessfully attempted to carry the day merely by repeating the generality that it must be safer in a hospital; a statement deceptively beguiling on its face, but grossly untrue, in fact.

The District Court expressly and specifically found:

> . . . the D&E procedure is the safest second trimester abortion technique currently available . . .

(J.A. 12).

> . . . second trimester D&E procedures are currently performed in only one hospital in Missouri.

(J.A. 12).

> . . . the expense of obtaining a second trimester D&E abortion in a hospital is significantly greater than that of obtaining the same procedure in an out-patient facility. Thus, requiring all second trimester abortions to be performed in a hospital places a financial burden on many women seeking such abortion.

(J.A. 14).

> During the time that section 188.025 was in effect in Missouri, primarily 1979, it was required that all second trimester abortions be performed in hospitals. During that period, the total number of second trimester abortion procedures performed was 540.[12]

(J.A. 14).

> In 1980, when second trimester abortions could be performed in both hospitals and out patient facilities, the total number of second trimester procedures performed in Missouri was 1390, 700 of which were performed in hospitals and 690 of which were performed in out patient facilities.[13] In 1979, when second trimester abortions could only be performed in hospitals, Dr. Henshaw testified that Missouri was meeting 13% of the perceived need for second trimester abortions in the state.[14] Alternatively, in 1980, when second trimester abortions could be and were

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[12] . . . in 1980, when both hospitals and out patient facilities could perform second trimester abortions, the number of second trimester abortions performed by hospitals did not decrease, but rather increased.

performed in both hospitals and out patient facilities, 34% of the perceived need for second trimester abortions in Missouri was met.

(J.A. 14).

. . . (that) requiring that all second trimester abortions be performed in a hospital resulted in the performance of fewer second trimester procedures than if the hospitalization requirement was not in effect.[11]

(J.A. 15).

As a result, section 188.025 creates a substantial interference with and imposes a direct burden on a woman's decision to have an abortion.

(J.A. 15).

The Appellate Court expressly and specifically found:

In 1973, when *Roe* was written D&E was not a well-known and common means of performing second trimester abortions.

(Cross-Pet. A-61).

. . . D&E is the most used and safest procedure for second trimester abortion.

(Cross Pet. A-116).

. . . nonhospital second trimester D&E procedures are no more dangerous to maternal health than hospitalized procedures.

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[11] In 1979, when second trimester abortions were only allowed in hospitals, 3.4% of all abortions performed in Missouri were second trimester procedures. This compared with a national average of 9%. In 1980, when second trimester abortions could be and were performed in both hospitals and out patient facilities, 7.9% of all abortions performed in Missouri were second trimester procedures.

(Cross Pet. A-119).

In the same appropriate manner that the Appellate Court deferred to the District Court in "an evaluation of the relative weight to be given the testimony of the experts" or "the credibility of the experts" (Cross Pet. A-66) and by reason that "the district court's finding is not clearly erroneous" (Cross Pet. A-119); this Honorable Court should defer and pay full respect to the findings of the Appellate Court and District Court below. The Appellate Court below faithfully adhered to the directions of this Honorable Court in *Inwood Laboratories, Inc.* v. *Ives Laboratories, Inc.*, 50 U.S.L.W. 4592, 4596 at n.20 (June 1, 1982) and in *Pullman-Standard, a division of Pullman, Incorporated* v. *Swint*, 50 U.S.L.W. 4425, 4430 at n.22 (April 27, 1982).

This Honorable Court's observations in *Inwood Laboratories, Inc.* and in *Pullman-Standard*, are particularly applicable here.

> Rule 52 broadly requires that findings of fact not be set aside unless clearly erroneous. It does not make exceptions or purport to exclude certain categories of factual findings from the obligation of a Court of Appeals to accept a district court's findings unless clearly erroneous. It does not divide facts into categories; in particular, it does not divide findings of fact into those that deal with "ultimate" and those that deal with "subsidiary" facts.

Pullman, supra, at 4429.

...An appellate court cannot substitute its interpretation of the evidence for that of the trial court simply because the reviewing court "might give the facts another construction, resolve the ambiguities differently, and find a more sinister cast to actions which the District Court apparently deemed innocent."

Inwood Laboratories, Inc., supra, at 4595, 4596.

> The Court of Appeals did not hold any of the District Court's findings of fact to be clearly erroneous, and this Court has frequently noted its reluctance to disturb findings of fact concurred in by two lower courts.

Rogers v. *Lodge*, 50 U.S.L.W. 5041, 5042 (July 1, 1982).

Other courts which have reviewed identical sections after full evidentiary proceedings have reached identical conclusions. *See Margaret S.* v. *Edwards*, 488 F.Supp. 181, 191-96 (E.D. La. 1980); and *Wolfe* v. *Stumbo*, 519 F.Supp. 22 (W.D.Ky. 1980), *remanded*, ____ F.2d ____ (6th Cir. September 17, 1981). As noted by Chief Judge Allen:

> The cases upon which the defendants rely, such as *Gary-Northwest Indiana Women's Services, Inc.* v. *Bowen*, 496 F.Supp. 894 (N.D.Ind.1980), are cases that this Court respectfully disagrees with, since they are based upon a misconception of the holding in *Roe* v. *Wade, supra*. The writers of those opinions failed to consider that the Supreme Court specifically held as early as 1973 in *Roe* v. *Wade, supra*, that medical knowledge is not a static thing, and that as medical knowledge and new techniques are evolved, the first trimester limitations may, in some instances, not be controlling. The *Gary-Northwest Indiana Women's Services, Inc.* v. *Bowen, supra*, case held that it was bound by the language of *Roe* v. *Wade, supra*, and, that in effect it was graven in stone. This completely overlooks the Supreme Court's reliance on improvements in medical techniques and skills which were involved in the Supreme Court's invalidating the saline instillation legislation in *Planned Parenthood* v. *Danforth, supra*.

Wolfe, supra, at 26. See Charles v. *Carey*, 627 F.2d 772 (7th Cir. 1980), *preliminary injunction affirmed.*

Although the Sixth Circuit in *Akron Center for Reproductive Health, Inc.* upheld a similar requirement by reason of its

misplaced reliance upon *Gary-Northwest Indiana Women's Services, Inc.* v. *Orr*, 451 U.S. 934 (1981), it was quick to note that in reviewing the opinions in *Planned Parenthood Association of Kansas City, Missouri, Inc.* and *Margaret S.* that "(t)he rationale of these decisions appears persuasive." 651 F.2d at 1210.

The Sixth Circuit's reliance upon *Gary-Northwest Indiana Women's Services, Inc.* v. *Bowen*, 496 F.Supp. 894 (N.D. Ind. 1980), *summarily affirmed* sub nom. *Gary-Northwest Indiana Women's Services, Inc.* v. *Orr*, 451 U.S. 935, (1981).

Initially, it must be noted that the Eighth Circuit in *Planned Parenthood Association of Kansas City, Missouri, Inc.*, while noting the summary affirmance by this Honorable Court in *Gary-Northwest, supra,* did not find the same to be decisive or precedential on the issue of an in-hospital requirement for second trimester abortions. (Cross Pet. A-58, A-61).

The District Court's opinion in *Gary-Northwest* was not a ruling upon the merits, but merely a denial of an applicaton for a preliminary injunction against the operation of an in-hospital requirement for second trimester abortions. This is abundantly clear from various language in the District Court's opinion.

> The case lay dormant until February 21, 1980, when the plaintiffs filed a petition for a hearing on the application of Mary Roe for preliminary and permanent injunctive relief against the enforcement of the Indiana abortion statute's hospitalization requirement for all second trimester abortions.

Gary-Northwest, supra, 496 F.Supp. at 896.

> Even if the plaintiffs' legal theory was accurate, the plaintiffs would have failed to justify a *preliminary injunction.*
>
> While this Court would be required to consider all relevant factors in deciding whether to exercise its discretion in favor of granting a *preliminary injunction,* the traditional

> standard for granting a *preliminary injunction* requires the petition to show (1) irreparable injury and (2) a likelihood of success on the merits. . . . The petition for a *preliminary injunction* is brought on behalf of women in their second trimester of pregnancy . . .

Id. at 902. (Emphasis supplied).

> The evidence produced at the hearing was insufficient to persuade this Court that the plaintiff would likely succeed
> * * *
>
> Thus, even if the plaintiffs' legal theory was accurate, the plaintiffs would have failed to justify a *preliminary injunction.*

Id. at 903. (Emphasis supplied).

The *Jurisdictional Statement* in *Gary-Northwest* (No. 80-1275), was docketed in this Court on January 27, 1981. On April 27, 1981, this Honorable Court, without formal decision, entered an order providing *in full* as follows:

> The judgment is affirmed. Justice Brennan, Justice Marshall and Justice Blackmun would note probable jurisdiction and set the case for oral argument.

451 U.S. 934 (1981).

The three questions presented were primarily procedural in nature, and not substantive. The first issue concerned the characterization of a motion as a Federal Rules of Civil Procedure No. 60(b) motion. The second contended that a full hearing on the merits was required. The third issue questioned whether the District Court had abused its discretion in refusing to issue a *preliminary injunction.* Only one conclusion can be drawn from this Court's summary affirmance on these three questions: The Court was satisfied that all procedural requirements had been met by the District Court below.

The *Jurisdictional Statement* is deemed the sole, appropriate source for determining the exact nature and essence of the issues presented to and decided by this Court.

> Summary affirmances . . . without doubt reject the specific challenges presented in the statement of jurisdiction and do leave undisturbed the judgment appealed from. They do prevent lower courts from coming to opposite conclusions *on the precise issues presented and necessarily decided* by those actions.

Mandel v. *Bradley,* 432 U.S. 173, 176 (1977). *See Illinois State Board of Elections* v. *Socialist Workers Party,* 440 U.S. 173, 182 (1979); and, *Gibson* v. *Berryhill,* 411 U.S. 564, 576 (1973).

None of the three issues presented to this Court in *Gary-Northwest* directly addressed the *merits* of the constitutionality of a second trimester, in-hospital requirement. Even the third issue concerning the alleged abuse of discretion in refusing to issue a preliminary injunction is not in any manner the same issue as a decision on the merits.

The procedural history of *Gary-Northwest,* amply demonstrates that the District Court denied a motion for *preliminary injunctive* relief. The appeal to this Court could only have been and was, in fact, from that judgment. This Honorable Court's summary affirmance can only be read, at most, as approval of such denial of *preliminary relief.* At least, it may be read as approving five years later the District Court's denial of the preliminary injunction, originally denied in 1975.

A case decided by this Court two days after *Gary-Northwest* emphasized the distinctly different legal issues involved between the granting of preliminary and of permanent injunctions. *University of Texas* v. *Camenisch,* 451 U.S. 390 (1981). This Court unanimously rejected out-of-hand a suggestion that a determination of the likelihood of success on the merits was tantamount to a decision on the underlying merits.

> This reasoning fails, however, because it improperly equates "likelihood of success" with "success," and what is more important, because it ignores the significant procedural differences between preliminary and permanent injunction.
>
> The purpose of a preliminary injunction is merely to preserve the relative positions of the parties until a trial on the merits can be held. Given this limited purpose, and given the haste that is often necessary if those positions are to be preserved, a preliminary injunction is customarily granted on the basis of procedures that are less formal and evidence that is less complete than in a trial on the merits. A party thus is not required to prove his case in full at a preliminary-injunction hearing. . . . and the findings of fact and conclusions of law made by a court granting a preliminary injunction are not binding at trial on the merits. . . . In light of these considerations, it is generally inappropriate for a federal court at the preliminary-injunction stage to give a final judgment on the merits.

451 U.S. at 394-95.

The precedential weight of *Gary-Northwest* is particularly weak, because this Court contrary to its custom did not cite a single case controlling the decision. If this Court had intended to *uphold* a second trimester in-hospital requirement on the basis of *dictum* in *Roe* v. *Wade,* 410 U.S. 113 (1973), surely it would have cited to its previous opinion. However, this it failed to do.

At least twice before in abortion related cases, this Honorable Court has summarily affirmed the decision of a lower court, citing the controlling case in support of its decision. *See Gerstein* v. *Coe,* 428 U.S. 901 (1976), *affirming,* 517 F.2d 787 (5th Cir. 1975); and, *Franklin* v. *Fitzpatrick,* 428 U.S. 901 (1976), *affirming,* 401 F.Supp. 554 (E.D.Pa. 1975). In both instances, the Supreme Court cited *Planned Parenthood of Central Missouri*

v. *Danforth,* 428 U.S. 52 (1976), indicating that the High Court considered the issues resolved by *Danforth. See Mahoning Women's Center* v. *Hunter,* 447 U.S. 918 (1980), *vacating and remanding,* 610 F.2d 456, 461 at n.11 (6th Cir. 1979). This Court granted certiorari, then vacated and remanded an abortion clinic regulation case on the attorneys' fee issue, citing two of its recent decisions on attorneys' fees.

Given the absence of a similar controlling citation in the summary affirmance of *Gary-Northwest,* the affirmance has little, if any, precedential value. This Honorable Court should undertake an independent review of the merits.

The legal import of summary affirmances has in recent years waned significantly.This Honorable Court unanimously articulated its current view of summary affirmances in *Illinois State Board of Elections* v. *Socialist Workers Party,* 440 U.S. 173 (1979), by reasoning:

> . . . that summary affirmances have considerably less precedential value than an opinion on the merits. See *Edelman* v. *Jordan,* 415 U.S. 651, 671 (1974). As Mr. Chief Justice Burger observed in *Fusari* v. *Steinberg,* 419 U.S. 379, 392 (1975) (concurring opinion), "upon fuller consideration of an issue under plenary review, the Court has not hesitated to discard a rule which a line of summary affirmances may appear to have established."

440 U.S. at 180-81.

> As we stated in *Mandel* v. *Bradley,* 432 U.S. 173, 176 (1977), the precedential effect of a summary affirmance can extend no farther than "*the precise issues presented and necessarily decided by those actions.*" A summary disposition affirms only the judgment of the court below, *ibid.,* quoting *Fusari* v. *Steinberg, supra,* at 391-392, (Burger, C.J., concurring), and *no more may be read into our action than was essential to sustain that judgment.* * * *

> Questions which "merely lurk in the record," * * * are not resolved, and no resolution of them may be inferred.

440 U.S. at 182-83. (Emphasis supplied).

As this Court noted in *Mandel* v. *Bradley*, 432 U.S. 173, 176 (1977):

> Because a summary affirmance is an affirmance of the judgment only, the rationale of the affirmance *may not be gleaned solely from the opinion below.*

(Emphasis supplied).

As manifestly evidenced: (1) by the "Questions Presented," (2) by the lack of any hearing on the merits by the District Court as to the constitutionality of an in-hospital, post-first trimester abortion requirement and (3) by the complete absence of any ruling by the District Court on the merits of such a requirement; this Honorable Court's summary affirmance, finding that the District Court did not abuse its discretion in refusing to issue a preliminary and interlocutory injunction in *Gary-Northwest* is neither binding, of precedential value nor persuasive on the similar issue now before this Honorable Court.

In *Margaret S.*, Judge Collins noting a study by the U.S. Department of H.E.W. that "operator skill is the critical factor in predicting risk of morbidity and mortality associated with abortion," concluded that:

> It would not promote maternal welfare to compel women to obtain post-first trimester abortions in hospitals, if they were available, where the doctors are almost totally inexperienced, rather than to allow women to benefit from the clinic doctor's expertise.

488 F.Supp. 195 at n.40.

This Honorable Court in *Planned Parenthood of Central Missouri* properly determined that "it was incumbent upon ap-

pellees to show that at the time of trial in 1974 prostaglandin was available." 428 U.S. at 77 at n.12. In the instant case, the Appellate Court similarly held that:

> If the district court finds the hospital requirement constitutes a direct interference with the woman's decision to have an abortion the court must then determine whether Missouri's requirement reasonably relates to the protection of the woman's health. *The State, in meeting this burden,* must show that nonhospitalized D&E can reasonably be considered more dangerous than hospital procedures, including hospitalized D&E. *It must also show* that the methods that it argues are as safe or safer than nonhospitalized D&E are actually available to Missouri women.

Cross-Pet. A-64. (Emphasis supplied).

Abortion is basically a medical procedure, particularly at the post-12 week gestation period. Determination of the appropriate medical setting and conditions is best left to the performing physician, subject in the unlikely event of abuse to "judicial and intra-professional" monitoring (*Roe,* 410 U.S. at 166) or to "professional censure and deprivation of . . . license." *Doe,* 410 U.S. at 199.

The relative safety of abortion compared to childbirth has increased since this Honorable Court's observation "of the now-established medical fact ... that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth." *Roe,* 410 U.S. at 163.

> At eight or fewer weeks' gestation, when more than half the procedures are performed, the risk of death from abortion was more than 20 times lower than that of childbearing. This difference declines as gestational age increases, but abortion remains the safer procedure with respect to the woman's life at gestational ages at least up through 16 weeks.

Cates, *et al., Mortality from Abortion and Childbirth,* THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, Vol. 248, No.2, July 9, 1982, pp. 188, 191.

The absolute arbitrariness of mandating all abortions, regardless of method, safety or other extenuating circumstances, to be performed in a hospital at a fixed stage of gestation, is constitutionally infirm.

III.

The Second Physician Requirement (MO.REV.STAT., § 188.030.3)

The requirement of this subsection that two doctors be in attendance throughout the abortion procedure is impractical, unnecessary, and burdensome. The techniques of terminating a viable pregnancy late in term often extends over many hours or even days. Requiring two doctors to be present not only strains medical resources, but places an enormous financial burden directly upon the woman seeking to terminate a pregnancy. (J.A. 127, Kretzschmar).

This Honorable Court in considering the regulation of medical practice at the stage of viability has reaffirmed its 1973 holding.

> Roe stressed repeatedly the central role of the physician, both in consulting with the woman about whether or not to have an abortion, and in determining how any abortion was to be carried out. We indicated that up to the points where important state interests provide *compelling* justifications for intervention, "the abortion decision in all its aspects is inherently and primarily, a medical decision," *id.*, at 166, and we added that if this privilege were abused, "the usual remedies, judicial and intra-professional, are available." Ibid.

Colautti v. *Franklin,* 439 U.S. 379, 387 (1979).

No compelling reason has been so demonstrated by defendants nor are there any reasons that the remedies suggested by this Court are not adequate to cure any breaches of medical or professional duty.

The imposition of a second physician, in situations where not the slightest possibility of the additional physician's presence or *raison d'etre* of the Section being realized, is neither a reasonable regulation nor a factor contributing to maternal health. (J.A. 128, Kretzschmar). *Roe,* 410 U.S. at 164. Two physician requirements relating to abortion have previously been invalidated. *Doe,* 410 U.S. at 198-200.

> Although the presence of a second physician to care for the child born as a result of a post-viability abortion certainly may further the state's interest in the protection of potential life, the attendance of a second physician during an abortion procedure which holds no possibility of fetal survival does not further that interest. The two-physician regulation is therefore overbroad and invalid on that basis.

Planned Parenthood Association of Kansas City, Missouri, Inc., (Cross Pet. A-27).

Contrary to defendants assertion that only Dr. Crist performed D&Es subsequent to viability (Defts. Br. 41), Dr. Kassar also performed these procedures, as found by the District Court. (Cross-Pet. A-18).

IV.

The Pathology Requirement (MO.REV.STAT., § 188.047)

The standards imposed by the First Circuit in *Baird* v. *Department of Public Health of the Commonwealth of Massachusetts,* 599 F.2d 1098, 1102 (1st Cir. 1979), and the Eighth Circuit in *Hodgson* v. *Lawson,* 542 F.2d 1350, 1353 (8th

Cir. 1976) and in *Freiman* v. *Ashcroft*, 584 F.2d 247, 251 (8th Cir. 1978), *summarily affirmed*, 440 U.S. 941 (1979) require that this Section be voided by reason of its encumbering effect upon the abortion decision, without any compelling state justification. Not only must this Section be stricken for its failure to exclude the first trimester period from its purview, but it is not even sustainable as a post-first trimester requirement, by reason of its utter failure to constitute a reasonable regulation for purposes of maternal health.

The only rationale for this Section's enactment is the *additional expense* of a pathology report on abortion at all stages of pregnancy, thereby increasing significantly the cost of the procedure and concomitantly decreasing its availability to women of limited resources.

As the Appellate Court observed:

> A "gross" examination is one unaided by a microscope. Pathologists may perform a gross examination or a microscopic examination if they feel it is necessary. This statute does not specify which type of examination the pathologist is to perform. Dr. J. Chandler Smith, Chairman of the Pathology Department at the University of Missouri Medical School, testified that with respect to abortions, a non-pathologist physician is just as capable of performing an adequate gross examination as is a pathologist, and that the abnormalities which are of concern are readily identifiable.

(Cross Pet. A-96 at n.37).

IV.

The Award Of Attorneys' Fees And Costs

Plaintiffs note this is the sole issue before this Honorable Court in *Hensley* v. *Eckerhart*, No. 81-1244, *cert. granted*, 50 U.S.L.W. 3695 (March 1, 1982).

Title 42, U.S.C., §1988 is a broad Congressional remedy mandating courts to award to a prevailing civil rights litigant "a reasonable attorney's fee as part of the costs." Accompanying that statute is Congressional legislative history providing detailed and precise guidance as to the application of the remedy. The legislative history of the Fees Act is remarkably replete and includes both a Senate Report, S. Rep. No. 94-1011, 94th Cong., 2d Sess. 1 (1976) and a House Report, H.R. Rep. No. 94-1558, 94th Cong., 2d Sess. 1 (1976). Both reports have been authoritatively cited by this Honorable Court. *See Maher* v. *Gagne,* 448 U.S. 122 (1980); *Hanrahan* v. *Hampton,* 446 U.S. 754 (1980); *Hutto* v. *Finney,* 437 U.S. 678 (1978).

In the legislative history of the Act, Congress expressly stated the appropriate standard for computation of a reasonable attorney's fee: "[i]n computing the fee, counsel for prevailing parties should be paid, as is traditional with attorneys compensated by a fee-paying client, '*for all time reasonably expended on a matter,*' " S. Rep. No. 94-1011, 94th Cong., 2d Sess. 6 (1976) (quoting *Davis* v. *County of Los Angeles,* 8 E.P.D. ¶9444 [C.D. Cal. 1974]) (emphasis added). Congress further indicated that the standard had been correctly applied in *Davis* v. *County of Los Angeles, supra,* 8 E.P.D. ¶9044 and in *Stanford Daily* v. *Zurcher,* 64 F.R.D. 680 (N.D. Cal. 1974).

Most Circuits have rejected a proportionality approach. *Lamphere* v. *Brown University,* 610 F.2d 46, 47 (1st Cir. 1979); *Seigal* v. *Merrick,* 619 F.2d 160, 164-65 (2nd Cir. 1980) (rejecting a proportionality approach to other complex federal litigation); *Jones* v. *Diamond,* 636 F.2d 1364, 1382 (5th Cir. 1981); *Northcross* v. *Board of Education of Memphis City Schools,* 611 F.2d 624, 636 (6th Cir. 1979); *Sherkow* v. *State of Wisconsin,* 630 F.2d 498, 504-05 (7th Cir. 1980); *Reproductive Health Services* v. *Freeman,* 614 F.2d 585, 600 (8th Cir. 1980); *Seattle School District No. 1* v. *The State of Washington,* 633 F.2d 1338, 1349 (9th Cir. 1980); *Littlefield* v. *Deland,* 641 F.2d 729, 732-33 (10th Cir. 1981); *Copeland* v. *Marshall,* 641 F.2d 880, 892 at n.18 (D.C. Cir. 1980).

Typical of the Circuits' reasoning is the holding in *Littlefield, supra.*

> . . . the clear intent of Congress in § 1988 was that the trial court award attorney's fees sufficient to attract and fully to compensate competent counsel. We stated further that attorney's fes should not be awarded for the pursuit of any frivolous issues or issues asserted in bad faith, but that they may be awarded for work upon issues of fact or law upon which plaintiff ultimately did not prevail so long as they were reasonably calculated to promote the client's interest.

641 F.2d at 733.

CONCLUSION

Since the prevailing legalization of aborton in 1973, under the aegis of *Roe* and *Doe,* abortion rates have increased up to 1980. In 1980, such rates peaked and subsequently have stabilized. Henshaw, *et al., Abortion Services in The United States, 1979 and 1980,* FAMILY PLANNING PERSPECTIVES, Vol. 14, No. 1, Jan./Feb. 1982.

Less than subtle efforts by politicians to satisfy misperceived constituent desires must not be condoned at the expense of constitutional guarantees and women's health; regardless of whether attempted under the guise of promoting childbirth or health concerns. The delivery of abortion services, in manners consistent with the free exercise of the attending physician's best medical judgment has been accomplished remarkably well.

The grant of constitutional credence to spurious efforts parading under a banner of maternal health can only produce the opposite and disastrous results of increased morbidity and mortality, associated historically with the denial of access to legal and safe abortions.

Repeated statutory efforts to undermine the solid wall of judicial resistance to the denial of a woman's and her physician's right to jointly decide on abortion, can not be allowed to succeed through annual legislative erosion or judicial attrition. The courage to act in a decisive manner, consistent with *Roe, Doe,* and their progeny is urged upon this Honorable Court.

This denial of access to the full enjoyment of constitutional rights has been encouraged by legislative interference, of which the challenged Sections here are sadly typical. The words of this Honorable Court many years ago, today still ring true,

> (C)onstitutional rights . . . can neither be nullified openly and directly by state legislators or state executive or judicial officers, nor nullified indirectly by them through evasive schemes . . . whether attempted "ingeniously or ingenuously."

Cooper v. *Aaron,* 358 U.S. 1, 17 (1958).

WHEREFORE, Respondents pray that the judgment of the Eighth Circuit Court of Appeals, declaring Missouri Revised Statutes, §§ 188.025, 188.030.3 and 188.047 unconstitutional and awarding to Respondents their reasonable attorneys' fees and costs, be affirmed and for such further orders as this Honorable Court deems appropriate.

Respectfully submitted,

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